Advance Care Planning Australia

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Subject – Community allied health	Level 1 skills / knowledge	Expected behaviour for case study
Case study Noelene is a 58 year old single woman who has chronic pain, fibromyalgia, chronic fatigue and is on a disability pension. Noelene lives at home and attended the pain management clinic for assistance with exacerbation of pain. Noelene stated that she lives alone. Noelene would prefer to remain at home but when the pain gets bad is concerned that she will be hospitalised particularly if she is in a situation where she is unable to communicate her preferences.		
Law	Explains that a person is presumed to have decision-making capacity unless there is reason to suggest otherwise	HCP assesses Noelene as being able to explain her health status, can provide a rationale for decision-making, and remember her decisions, therefore has capacity.
	Recognises and locates relevant advance care planning documents and identifies the person's substitute decision-maker	HCP is aware of how to document advance care planning discussions for their workplace.
	Demonstrates appropriate processes to add an advance care planning document alerts on local systems	HCP can put an alert into the system and can talk to Noelene about how she may want to alert ambulance service, GP and other relevant services of any advance care plans or SDM appointment.
Communication - with the person / family / carers	Explains advance care planning and can provide general information about it	Healthcare professional (HCP) asks whether Noelene has thought about advance care planning and can explain the benefits.
	Recognises trigger factors where advance care planning may assist a person and can refer to others	HCP recognises the triggers and risk factors for Noelene are her limited social support; chronic conditions and frequent exacerbations of pain.
	Initiates an advance care planning discussion	HCP identifies that an advance care planning discussion with Noelene is appropriate.
	Reflects on their	HCP reflects on their values as they relate to

	personal values and preferences and can differentiate between these and consumer agenda	experiencing chronic pain and its impact on quality of life. HCP can focus on Noelene's experience and ask her what she enjoys most in her life (can start to guide values discussion).
Communication - with the team	Identifies the contribution of all health professionals and care workers in a person's advance care planning discussions	HCP is able to recognise the chronic conditions experienced by Noelene. As Noelene is attending a pain management clinic, HCP states at the team meeting Noelene's concerns about returning to hospital and recommends advance care planning discussions be started. HCP recommends to Noelene to discuss her preferences for care with her GP.
	Recognises and discusses when treatment interventions may not match stated values and preferences for care	HCP recognises that limited social support may affect Noelene's ability to remain at home and explores with Noelene to consider if there might be an acceptable time for a hospital admission. Encourages Noelene to explore this further with the medical specialist and the GP.
	Is aware of processes to receive, store and share advance care planning documents	HCP documents advance care planning discussions with Noelene and encourages Noelene to share copies of any completed advance care directives or appointed SDM documents with the GP, specialist and local hospital.
Ethics	Recognises that there may be different perspectives between the goal of the person, the substitute decision-maker and the healthcare team	HCP can explain to Noelene that if a SDM is appointed she should speak to them about her preferences for care and provide suggested criteria for choice of SDM.
	Explains to the person with sufficient capacity that they can guide the healthcare team regarding interventions	HCP states to Noelene that a SDM could speak for her if there came a time when she could not speak for herself and documented preferences would guide decision-making.
Communication - over time	Identifies what the person wants to achieve from the advance care planning discussion	HCP recognises that Noelene may want to document her preferences for care and any appointed substitute decision-maker (SDM). HCP provides written information to support discussion on advance care planning.
	Recognises triggers to review advance care planning documents	HCP suggests to Noelene to think about advance care planning and appointing a SDM. HCP recognises that another hospital admission is likely and having documentation may assist with care.

	Recognises the loss of decision-making capacity and discusses this with the healthcare team	HCP can state advance care planning can help guide treatment interventions if there is a time that Noelene is not able to speak for herself.
	Informs the team of the existence of any advance care planning documents	HCP documents advance care planning discussions, and the need for further follow up.

Points of assessment / discussion	Identifying benefits of someone with chronic disease and regular hospital admissions in considering an ACP. Aware of available resources and the need to communicate with the healthcare team.
Method of assessment	MCQ regarding triggers for discussion, advocating for pt. in MDT discussions.